

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 10-13-03.

The IRO reviewed outpatient physical therapy/occupational therapy consisting of myofascial release, neuromuscular re-education, special supplies, ultrasound therapy, therapeutic exercises, electric stimulation, therapeutic activities and hot/cold pack therapy rendered from 12-09-02 through 03-24-03 that were denied based upon “U”.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
12-09-02 through 2-6-03 (15 DOS)	99070	\$120.00 (1 unit @ \$8.00 X 15 DOS)	\$0.00	U	DOP	IRO Decision	Reimbursement recommended in the amount of \$8.00 X 15 DOS = \$120.00
12-9-02 through 2-7-03 (20 DOS)	97250	\$1,000.00 (1 unit @ \$50.00 X 20 DOS)	\$0.00	U	\$43.00	IRO Decision	Reimbursement recommended in the amount of \$43.00 X 20 DOS = \$860.00
12-9-02 through 2-7-03 (20 DOS)	97112	\$900.00 (1 unit @ \$45.00 X 20 DOS)	\$0.00	U	\$35.00	IRO Decision	Reimbursement recommended in the amount of \$35.00 X 20 DOS = \$700.00
12-9-02 through 2-7-03 (20 DOS)	97110	\$900.00 (1 unit @ \$45.00 X 20 DOS)	\$0.00	U	\$35.00	IRO Decision	Reimbursement recommended in the amount of \$35.00 X 20 DOS = \$700.00
12-9-02 through 2-6-03 (15 DOS)	97035	\$450.00 (1 unit @ \$30.00 X 15 DOS)	\$0.00	U	\$22.00	IRO Decision	Reimbursement recommended in the amount of \$22.00 X 15 DOS = \$330.00
1-15-03 through 2-7-03 (7 DOS)	97530	\$315.00 (1 unit @ \$45.00 X 7 DOS)	\$0.00	U	\$35.00	IRO Decision	Reimbursement recommended in the amount of \$35.00 X 7 DOS = \$245.00
12-12-02	99070	\$176.00	\$0.00	U	DOP	IRO	No reimbursement

through 3-24-03 (22 DOS)		(1 unit @ \$8.00 X 22 DOS)				Decision	recommended.
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
12-17-02 through 3-24-03 (25 DOS)	97250	\$1,250.00 (1 unit @ \$50.00 X 25 DOS)	\$0.00	U	\$43.00	IRO Decision	No reimbursement recommended.
12-12-02 through 3-24-03 (13 DOS)	97112	\$630.00 (2 units @ \$90.00 for 1 DOS and 1 unit @ \$45.00 X 12 DOS)	\$0.00	U	\$35.00	IRO Decision	No reimbursement recommended.
12-12-02 through 3-17-03 (16 DOS)	97110	\$720.00 (1 unit @ \$45.00 X 16 DOS)	\$0.00	U	\$35.00	IRO Decision	No reimbursement recommended.
12-12-02 through 3-24-03 (24 DOS)	97035	\$720.00 (1 unit @ \$30.00 X 24 DOS)	\$0.00	U	\$22.00	IRO Decision	No reimbursement recommended
12-12-02 through 3-20-03 (14 DOS)	97014	\$300.00 (1 unit @ \$20.00 X 13 DOS, 2 units @ \$40.00 X 1 DOS)	\$0.00	U	\$15.00	IRO Decision	No reimbursement recommended
1-22-03 through 2-24-03 (6 DOS)	97530	\$270.00 (1 unit @ \$45.00 X 6 DOS)	\$0.00	U	\$35.00	IRO Decision	No reimbursement recommended.
2-20-03 through 3-24-03 (15 DOS)	97010	\$320.00 (1 unit @ \$20.00 X 14 DOS, 2 units @ \$40.00 X 1 DOS)	\$0.00	U	\$11.00	IRO Decision	No reimbursement recommended.
TOTAL		\$8,071.00					The requestor is entitled to reimbursement of \$2,955.00

The IRO concluded that myofascial release, neuromuscular re-education, special supplies, ultrasound therapy, therapeutic exercises, electric stimulation, therapeutic activities and hot/cold pack therapy from 12-09-02 through 2-7-03 at a frequency of three (3) times per week **were** medically necessary. The IRO concluded that myofascial release, neuromuscular re-education, special supplies, ultrasound therapy, therapeutic exercises, electric stimulation, therapeutic activities and hot/cold pack therapy after 2-7-03 and for dates of service 12-12-02, 12-17-02, 12-19-02, 01-02-03, 01-07-03, 01-09-03 and 01-22-03 **were not** medically necessary.

On this basis, the total amount recommended for reimbursement **(\$2,955.00)** does not represent a majority of the medical fees of the disputed healthcare and therefore, the requestor did not prevail in the IRO decision. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 01-22-2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
11-15-02 through 12-17-02 (3 DOS)	99070	\$24.00 (1 unit @ \$8.00 X 3 DOS)	\$0.00	NO EOB	DOP	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
11-5-02 through 1-24-03 (4 DOS)	97250	\$200.00 (1 unit @ \$50.00 X 4 DOS)	\$0.00	NO EOB	\$43.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
11-5-02 through 1-24-03 (4 DOS)	97112	\$180.00 (1 unit @ \$45.00 X 4 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
11-5-02 through 1-24-03 (4 DOS)	97110	\$180.00 (1 unit @ \$45.00 X 4 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A-F)	See rationale below. No reimbursement recommended.
11-5-02	97035	\$60.00	\$0.00	NO	\$22.00	Rule	Requestor did not submit relevant

through 11-11-02 (2 DOS)		(1 unit @ \$30.00 X 2 DOS)		EOB		133.307 (g)(3)(A- F)	information to support delivery of service. No reimbursement recommended.
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DOS	CPT CODE	Billed	Paid	EOB Denial Code	MARS (Maximum Allowable Reimbursement)	Reference	Rationale
1-23-03 through 1-24-03 (2 DOS)	97530	\$90.00 (1 unit @ \$45.00 X 2 DOS)	\$0.00	NO EOB	\$35.00	Rule 133.307 (g)(3)(A- F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		\$734.00	\$0.00				The requestor is not entitled to any reimbursement.

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

This Decision is hereby issued this 11th day of May 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 12-09-02 through 02-07-03 in this dispute.

This Order is hereby issued this 11th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 5, 2004

AMENDED DECISION

MDR Tracking #: M5-04-0448-01

IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon reviewer (who is board certified in Orthopedic Surgery who has an ADL certification). The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This independent review concerns a then-48 year-old right-handed female kitchen worker who sustained an injury to her left elbow and shoulder while on the job ___. Apparently as she was cleaning under a table, she lifted a chair with resultant pain to that elbow and shoulder. With the resultant pain, she was removed from the work setting and apparently has not returned to work since that time. After considerable conservative management including extensive physical therapy, as well as MRI studies of the shoulder and elbow and EMG studies with fairly benign findings, she ultimately underwent arthroscopic subacromial decompression with acromioclavicular joint resection on 09/19/02, for some element of bursitis and impingement as well as acromioclavicular joint degenerative/post-traumatic changes. At the same setting, she underwent open fasciotomy and perhaps some element of debridement to a persistent medial epicondylitis of the inter elbow (golfer's elbow). Subsequently, despite further injections, extensive physical/occupational therapy, a multitude of medications, psychological counseling, and chronic pain management in consideration of some element of sympathetic dystrophy, she has continued with pain about the elbow as well as now apparently about the neck and shoulder girdle.

Requested Service(s)

Outpatient physical therapy/occupational therapy to consist of: myofascial release, neuromuscular re-education, special supplies, ultrasound therapy, therapeutic exercises, electric stimulation, therapeutic activities and hot/cold pack therapy rendered between 12/09/02 – 03/24/03.

Decision

The initiation of a course of physical therapy (to include all modalities as listed in requested services) on 12/9/02 appear to be medically necessary, but at a frequency of 3X/week. After an 8-week period of time, the lack of objective documentation of efficacy, fails to support continued physical therapy services. No PT sessions (all modalities included), subsequent to 2/7/03 appear to be medically necessary. PT sessions (all modalities included), therefore, on 12/12/02, 12/17/02, 12/19/02, 01/02/03, 01/07/03, 01/09/03, and 01/22/03 are not considered to be medically necessary, in addition to sessions subsequent to 2/7/03.

Rationale/Basis for Decision

While the documentation is difficult to fully solidify, it appears that the maximum requested therapy services were for three times per week during that time frame. Review of the “Table of Disputed Services” indicates that therapy was provided up to 5X/week during some weeks. Additionally, many times, when delivered 3X/week, it was not spaced on a MWF schedule. Physical therapy services, (including all listed modalities) at this point, should have been provided no more frequently than 3X/week. There should have been an incorporation of physical therapy directed at all injured body parts by the physical therapist, during the three weekly sessions. A maximum evaluation period of 8 weeks should have been used. The documentation fails to show significant objective gains, after the first 8 weeks of therapy that would support continuation of this program.